The Coding News

Population Health Support Division

SUMMER 2003

Hot!

Improving Medical Recording Coding at Military Treatment Facilities (MTFs)

William Winkenwerder, Jr., MD, Assistant Secretary of Defense for Health Affairs, has signed a memorandum, improving Medical Record Coding at Military Facilities, dated 20 Aug 03 (memorandum is currently in coordination with the services), which proposes to establish the following compliance standards for coding at DoD MTFs:

a. 100% of all outpatient encounters, other than ambulatory procedure visits (APVs), should be coded within three business days of the encounter
b. 100% of APVs should be coded within 15 days of the encounter
c. 100% of inpatient records should be coded within 30 days after discharge
d. 100% medical record coding accuracy

AFMOA/SGZZ is preparing a response plan for AF/SG; expect to hear additional guidance concerning implementation in the near future.

How Accurately Are We Coding?—Internal Audits

The new audit methodology policy requires that MTFs to perform an audit on each clinic twice annually. This policy established a standard process for reviewing a random sampling of records for specific clinics in accordance with (IAW) a rotating clinic schedule. Under this policy, not only will the coding accuracy be assessed, but MTFs will be reporting their rate of record availability as well. Since this new auditing methodology replaces the guidance in AFI 41-210, Patient Administration Functions, the audit results will be reported on the MTF Commander's Data Quality Statement **and reported to AFMOA by the l5th** of the month for clinics listed on the Clinic Rotation for the previous month.

Auditors will want to assess the workload based on the Clinic Rotation

The Population Health Support Division (AFMOA/SGZZ)

Our Mission

We support DoD health professionals in optimizing the health and wellness of their populations through appropriate, effective, and efficient healthcare practices and service delivery.

Our Vision

Become the most trusted name in population health and health services support.

Inside this issue:

Schedule, since 139 records are to be reviewed for each clinic and distribute it accordingly for the six month period. For example, June may have only one clinic to audit, but July has four clinics and August has two. Submission of the report for the clinics listed on the rotation schedule is most important; therefore, the record, regardless of the encounter date, can be reviewed anytime during the six-month period. Naturally, an auditor would want to review the most current records possible, or at least within the last six months. The Pull List for Audit Review (PLAR) should have enough records listed to allow record personnel to pull the 139 required records.

MTFs will soon have new management tools available on P2R2 and Biostatical Data Quality Assessment (BDQAS) websites to compare their coding accuracy performance with other sites and quickly identify areas with have opportunities for improvement.

Considering sites had a very short notice to transition to this new methodology, the efforts the AFMS coding auditors exhibited to meet these first three suspenses for June, July and August were superb!

New Courses Available on LearnLinc Web Based Training Program

Notice to your inpatient coders! Two new courses are now available for inpatient coders to obtain continuing education credit on the web based LearnLinc program. One two-hour course covers the rules applicable to inpatient coding, proper coding for obstetrical patients, neoplasms, injuries, external cause of injuries and inpatient procedures. The other course provides instructions for coding for inpatient professional services, otherwise known as Industry Based Workload Alignment Workload (IBWA). Upon completion of the course pre and post tests, a certificate of completion will be sent to students. This is an excellent source to improve your coding skills and earn continuing education credits for maintaining accreditation.

To access the courses:

1. Log in to LearnLinc at https://starview.brooks.af.mil/learnlinc
2. Select Create an Account
3. Enter your name, account ID (you choose), password (you choose), and e-mail address
4. Install LearnLinc 5.1, Standard Classroom, from the web
5. For the Setup Wizard – select Yes and Next
6. For the Audio Wizard – select Speakers and follow the prompts to ensure you can hear
7. Select Finish
8. Select "Your" Home Page
9. Under Population Health Coding Courses, click on the + next to Course Materials
10. Select a module

If you have any questions, please call the Population Health Support Division (PHSD) HELP Desk at DSN 240-8190, (210) 536-8190, or 800-298-0230. They can refer you to the appropriate consultant.

Documentation of Inpatient Professional Services for IBWA

In order to capture the inpatient professional services documentation has to exist in the medical record. It must be there to capture the initial hospital encounter, any subsequent encounters during the hospitalization, and discharge services provided.

The initial encounter a patient has with the admitting/attending provider is the encounter that is coded. The date of this encounter may not be the same as the date of the admission. The initial services provided by the admitting/attending physician should include all E&M services provided to that patient in conjunction with the admission that occurs on the same date. Complexity of care and time are factors in assigning the appropriate E&M codes. Ensure the history, exam, and medical decision making factors are present along with the time spent with the patient.

Initial hospital care services will be documented and coded for admission and discharges on the same date. Subsequent hospital care will be coded when the attending physician (or other physi-

cian providing concurrent care) documents he has seen the patient. These encounters may be daily or possibly every three days. As part of the note, an interval history is needed on the patient—meaning any new history information that has been obtained since the last physician/patient encounter.

Time also plays a factor in the E&M code assignment—the time spent is based on complexity of the illness/injury and how responsive the patient is to treatment. Time spent with the patient and the coordination of care must be documented. The total time spent by the physician to finalize the hospital discharge services of the patient will be reported. Services include final exam of the patient, discussion of the hospital stay, instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions, and referral forms.

Discharge services are reported on patients whose discharge date is different from the admission date and time spent performing these activities should also be documented. Discharge services will also be documented when a patient dies during the hospitalization. Documentation includes the final exam (pronouncing the patient dead), discussing the stay with family members, and preparing the discharge records (the discharge summary for the hospital record).

Physicians, who have residents caring for patients, are responsible for reviewing the documentation as well as being present during the key components of the encounter. It is no longer acceptable to write "concur/agree" and sign just the note. Presence during the encounter and evidence of review must be documented. Some examples of acceptable documentation are:

1) Initial or follow-up visit: "I was present with the resident during the history and exam. I discussed the case with the resident and agree with the findings and plan as documented in the resident's note."

2) Follow-up visit: "I saw the patient with the resident and agree with the resident's finding and plan."

Initiatives

3M Health Information Systems Hits the Air Force Medical Service (AFMS) With a Storm

By now many of you have either heard of the external coding audit that is being performed by 3M Health Information Systems or have had the pleasure of hosting the 3M staff at your MTF. In either case, the project has been an exciting venture for the Air Force Medical Service and has certainly proven to help with meeting the goals and objectives of increasing coding accuracy in our great service!

Evolution of the 3M External Coding Audit Contract

In Jan 03, AFMOA/SGZZ approved a contract with 3M Health Information Systems (3M HIS) to perform external coding accuracy/compliance audits. This will be accomplished by reviewing approximately 250 coded outpatient records (will vary based on facility workload/complexity) at 43 Peer Group 3, 4, and 5 military treatment facilities (MTFs). Facilities were selected due to the size and complexity of coded encounters and their impact on population health data and revenue generation. The contract also includes root cause analyses, training, and benchmarking with the civilian healthcare industry. Legal requirements for Health Insurance Portability and Accountability Act (HIPAA) compliance are addressed in the contractor's statement of work. Coding audits and education sessions will be scheduled in advance with each MAJCOM and MTF.

Audits will be conducted through one of two methods; either on-site review of select coded records by professional coding staff from 3M, or through MTF transmission of selected outpatient record documentation to 3M utilizing a secure scanner provided by the contractor. It is anticipated that depending on the size of the MTF, it will take from 2 - 4 business days for the audit to be com-

pleted. Following each audit, 3M HIS will create a report of their findings and will follow-up with the MTF approximately 30 days after the audit to conduct targeted coding training for both clinical and coding staff at the MTF.

Current Findings and Feedback

Currently, 3M has audited 16 MTFs and have provided 8 onsite training sessions. Although no one enjoys the thought of being audited, this project has been well received. The largest issue found to date has been lack of documentation where either the medical record was not available or the actual note in the records was just not there. The percentage of non-availability ranges from 14-25 percent! The next major concern was no surprise, which is the code used did not accurately coincide with the entry made for that particular visit – coding accuracy. All MTFs need to be mindful of the fact that coding accuracy, completeness, and timeliness are getting a great deal of attention from OSD (Health Affairs), Dr. Winkenwerder. In response, the AFMS is very interested in the coding results of both the 3M external audits and each MTFs internal audits. PHSD will continue to develop programs and guidance designed to facilitate each MTF's coding processes and to provide AFMS and DoD leadership with the most accurate picture of coding progress.

On the positive side, legibility seems to be very good and we certainly know by BDQAS that Ambulatory Data Module (ADM) completion has been superb. The training that 3M has provided has received great accolades. Coders/Auditors were reluctant at first, but after hearing the 3M Professionals and the manner in which the training was provided, the response was absolutely positive as a great learning experience.

Future Audits

We're a little half way completed with the audit schedule, so please be prepared when asked to host the visit by 3M. The PHSD staff will soon be contacting the MTF and will provide all the information needed to support the audit. The time and space needed by the auditors will not affect any inspections that may be occurring in your facility, so please try not deviate from the proposed schedule. We will certainly work with you all to ensure the visit is convenient and seamless as possible.

Completing the Revenue Cycle

Use -51 Modifier Sparingly and Carefully

Misuse could cut payments! Clinical practices bill modifier -51 (multiple procedures during the same encounter) to Medicare millions of times a year. But experts say it often may not be necessary to append the modifier to a code, and doing so wrongly could cost you legitimate reimbursement.

The -51 modifier is intended for use when billing for multiple surgeries performed by a single physician (or physicians in the same group practice) on the same patient at the same operative session or on the same day. (The same rules also apply when co-surgeons, surgical teams or assistants-at-surgery participate in the procedures, according to the Medicare Carriers Manual, Sec. 4826).

The modifier is not used when two physicians perform different, unrelated surgeries on the same patient on the same day (as in some trauma cases). It's also not used when the multiple procedures are bundled together by the national Correct Coding Initiative (CCI). That's what the -59 modifier is for, to unbundle CCI edits, says Lisa Stavrakas, a coding consultant with the Medical Group Management Assn., Englewood, Colo.

Billing experts say listing the -51 modifier on a claim is usually unnecessary. Medicare doesn't require it, and many payers - including Medicare - will add it automatically anyway. "Use it judiciously, like salt... only when you know it's necessary," says Inga Ellzey, head of Inga Ellzey Practice Group, a dermatology consulting firm in Casselberry, Fla.

Here's how it works: Anesthesiologists might use the -51 modifier for certain pain management procedures, says Lisa Griffin CPC, a coder with

Medac, an anesthesiology billing firm in Augusta, Ga. "If the patient has an occipital nerve block in the upper spine joint, but the patient is also having unrelated pain in the sacral-iliac joint, on the other end of the spine and a nerve block was also done on this area, we'd attach a modifier -51 in that instance," she says.

Practitioners billed the -51 modifier more than 9 million times in 2001, compared with more than 14 million for the -59 modifier, according to a Part B News analysis of Medicare billing data. Dermatologists billed modifier -51 more than any other specialty, accounting for more than 20% of the billing of that modifier.

Costly errors are created. Using the -51 modifier can actually decrease revenue, if you're not careful, says Sharon Andrews, owner of DermResources, a consulting firm in Pensacola, Fla. Here's how: Ordinarily, if multiple procedures are performed on the same patient at the same encounter, bill the one with the highest relative value units (RVUs) without the -51 modifier, and attach the modifier to the rest of the applicable procedures (with lower RVU values). The -51 modifier will alert the payer to cut the attached code in half. But "there might be a payer who doesn't cut multiple surgeries unless they are told to," Andrews says. "51 is a flag to make sure it gets cut in half." Payers - especially Medicare - are perfectly capable of cutting reimbursements for multiple procedures on their own, experts agree. (Though Medicare cuts payments by 50%, some payers reduce by different amounts.)

“Further, unless the insurance company has given you its fee schedule, you don't always know what procedures the payer values the highest,” Andrews says. And coders can make mistakes, attaching -51 modifiers to higher-paying codes and losing reimbursement.

Example: Code 11642 (excision of malignant lesion from face) pays $223.29 (par, national, physician office) and 13131 (repair of wound) pays $291.34 (par, national, physician office). A physician would most likely write 11642 first and 13131 second, Ellzey says. A biller might simply attach the -51 modifier to the second code, even though it is the more expensive procedure. That mistake would cost the facility about $35.

TIP: Check with payers to see if they require the modifier, Andrews says. Many don't, and some, like TrailBlazer Health Enterprises, the Part B carrier in Virginia, actively discourage it. Don't append the modifier unless you have something in writing that says the carrier wants it in a particular situation, Ellzey recommends.

If you still want to use the modifier, here are a few tips to remember:

- Do not reduce your price, says Jo Ann Steigerwald, senior consultant, the Wellington Group, Baraboo, Wis. "When you submit the reduced price with the -51 modifier, sometimes [payers] will re-reduce your price," she says. "Bill at 100% for everything, and let the payer reduce it."
- Do not use modifier -51 with add-on codes or codes that are -51 exempt. An example of an add-on code (+) is 17003 (destruction of benign or pre-malignant lesion, second through 14th lesion, $10.30, par, national, physician office). This code cannot be billed without 17000 (destruction of benign of pre-malignant lesion, $61.43, par, national physician's office), and the relative value units for 17003 are already lowered. Other codes are exempted from use with the -51 modifier, and these are marked in the CPT book with a Ø.
- Don't use the modifier with non-invasive diagnostic tests. Lab tests and X-rays, even if you perform 10 of them on the same day, should not be billed with the -51 modifier. - E. Klein.

Billing for colonoscopies: when they are and aren’t payable.

Tests that are performed in the absence of signs, symptoms, complaints, and personal history of disease or injury are <u>not covered</u> except when there is a statutory provision that explicitly covers a test for screening.

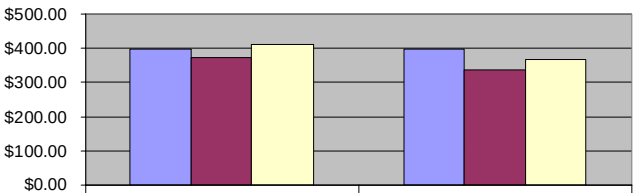
Colorectal cancer screening colonoscopies are payable for Medicare patients age 50 and older, meaning one every 24 months for a patient at high risk for colon cancer (**G0105**, colorectal screening; high risk individual, APC 0158, $368.38, national)

and one every 10 years, but not within 48 months of a screening flexible sigmoidscopy on an individual not meeting criteria for high risk (**G0121**, colon carcinoma screening not high risk individual, APC 0158, $368.38).

If a patient presents with a diagnostic implication, such as signs, symptoms and/or chief complaints, any test performed would be considered diagnostic, not screening. Example: a patient presents for abdominal pain and rectal pain (789.00 & 569.42), and a diagnostic colonoscopy was performed (**45378**, diagnostic colonoscopy, APC 0143, $412.85).

It is important to note a screening colonoscopy links to APC 0158, and diagnostic colonoscopy links APC 0143.

Screening vs. Diagnostic Colonoscopy
CPT Codes 45378 APC 0143 and G0105, G0121 APC 0158
Unadjusted National Payment



	APC 0143	APC 0158
2001	$395.78	$395.78
2002	$372.11	$335.46
2003	$412.85	$368.38

Identify five steps to ensure you receive your payment:

Coding Tip: If during the screening procedure, a biopsy is obtained (**45380**, colonoscopy and biopsy, APC 0143) or polyp is removed (i.e. **45385**, lesion removal colonoscopy, 0143), then the appropriate procedure code is reported in lieu of G0105 or G0121. Never report both G0105 or G0121 in addition to the colonoscopy procedure code(s).
Modifier Tip: The rule of modifier -52, reduced services, for outpatient PPS is based upon procedures without anesthesia or with intravenous (IV) conscious sedation. Review modifier -52 definitions in program memo A-00-73 (http://www.partbnews.com/htm/A-00-73.htm). It could be helpful considering the high volume of sedated procedures in the gastrointestinal endoscopy area. This modifier can be appended to either Level I CPT or Level II HCPCS codes when documentation supports it.
ICD-9-CM Tip: According to Transmittal 769 (http://www.partbnews.com/htm/MHM769.htm), colonoscopies performed on patients must be identified with one of the following specific ICD-9-CM diagnosis codes on the UB-92 claim form submission: V10.05, V10.06, V16.0, V12.72, V18.5, 555.0, 555.1, 555.2, 555.9, 556.0, 556.1, 556.2, 556.3, 556.8, 556.9, 558.2, 558.9. Check your FI's LMRP for further codes and sequencing rules.
CDM Tip: Check your current gastrointestinal department's CDM to ensure that duplication of coding efforts are thwarted. Remember, typically it's the responsibility of your HIM outpatient coding staff to assign the above codes based on physician documentation.
Billing Tip: Check current submissions of electronic claims to your FI. A unit of one (1) is reported for the above series of codes. Many times internal facility charging is set per 15 minutes or more for this area and in turn, your internal system should be rounding it to a unit of one with charge. *(Article excerpted from Focus on Reimbursement, by, Andrea Clark, RHIA CCS CPC-H, President, Health Revenue Assurance Associates, Chapel Hill, N.C)*

Billing for Ambulance Runs

For MTFs who maintain and/or contract for ambulance services, even though billing must be hand-keyed and billed on UB-92 Claim Form in TPOCS; runs still must be coded. Ambulance billing will be based on the appropriate MEPRS code FEA*. The ambulance service will be coded from the run sheet. If a technician is providing care for the patient during the ride, 99211 is the appropriate Evaluation and Management code.

The diagnosis codes would be based on the symptoms or injuries noted at the time patient was picked up. All procedures and services performed during the trip would be coded (HPCPCS A0000-A0999). The charges will be based on hours of service in 15-minute increments. The hourly charge

for Ambulance is all-inclusive. Supplies and mileage should not be billed separately at this time. MTFs will calculate charges based on the number of hours (and/or fractions of an hour) the ambulance is logged out on a patient run. Fractions of an hour shall be rounded up to the next 15-minute increment (e.g., 31 minutes shall be charged as 45 minutes). You may refer to the Medical and Dental Services Rate Package-Current Fiscal Year for more information.

General Info

Central Purchase of Coding Reference Material

At the time this newsletter is being published, a central purchase of coding books is pending availability of funds. However, there is no guarantee that this will occur. If this does not occur, MTFs will be responsible for purchasing their own references.

Sometime in 2004, MTFs will be receiving ADM software versions with the Correct Coding Initiative (CCI) edits that will include a tool similar to the Code Manager which contains current ICD9-CM, CPT and HCPCS codes.

There are several companies who supply ICD-9-CM, CPT and HCPCS code books, quarterly publications and other useful resources; listed below are sources you may contact for prices:

American Medical Association
515 North State Street
Chicago, IL 60610
Tele #: 800-621-8335
E-Mail: www.amapress.com

Ingenix (Medicode)
St Anthony Publishing Company
2525 Lake Park Blvd
Salt Lake City, UT 84120
Tele #: 1-877-464-3649
E-Mail: www.ingenixonline.com

American Hospital Association
One North Franklin
Chicago, IL 60606
Tele #: 1-800-242-2626

Attached is a list of the 2004 ICD-9-CM code revision/changes. (Attachment 2)

How to Code Audiology Encounters

Audiology is one of the specialties with special coding guidance in the medicine section of CPT. Audiology also has many HPCPS codes in V5000-V5999.

It is very uncommon for an audiologist to have a visit without doing a procedure. An example would be a hearing aid patient complaining of ear pain, found to have scratched auditory canal and advised on proper hearing aid procedures. This encounter would be coded based on the chief complaint (for the diagnosis) and the history, exam and decision making/risk (for the E&M).

Codes 92502 through 92526 are only for the procedure and do not include evaluation. In this case, if evaluation and management are done, as well as the procedure, it is appropriate to code both using a modifier –25 on the E&M.

Most audiology workload can be collected using codes 92531 through 92604. Codes 92531 through 92604 include the evaluation so usually the E&M field will be completed with 99499 as a placeholder indicating a privileged provider furnished the services. When using the 99499 E&M with a procedure code, do not use the –25 modifier.

When selecting procedure codes, ensure you understand exactly what is included. For instance, a “comprehensive” audiometry threshold evaluation (92557), for coding purposes, only includes air and bone pure tone audiometry and speech recognition speech audiometry. It does not include tympanometry (92567), acoustic reflex testing (92568) or acoustic reflex decay testing (92569). When these other procedures are performed as well as the “comprehensive” audiometry threshold evaluation, they should also be coded.

At the present time, only the first four proce-

dures will be collected in the SADR. Therefore, to best indicate workload, be sure to code the most labor and risk intensive procedures in the first four procedure fields. For instance, collect limited evoked otoacoustic emissions (92587), which earns 1.54 total non-facility relative value units (RVUs), instead of acoustic reflex testing (92568) which earns 0.39 total non-facility RVUs in the primary position.

When coding multiple procedures, the primary procedure (e.g., 92557) will not have a "multiple procedure" modifier, but all additional procedures will have the "multiple procedure" modifier (e.g., 92587-51, 92567-51 and 92569-51).

Hearing Conservation.

Audiometric procedures done and interpreted in hearing conservation should be collected in hearing conservation**.** Procedures done by privileged providers are coded with an E&M of 99499. Procedures done and interpreted by a technician are coded with an E&M of 99211.

Use of V57.1 as Primary Diagnosis for Physical Therapy Encounters

Since auditors just completed the review of the Physical Therapy records this past month, many questions have risen concerning the appropriate use of codes for these clinics. The current "Professional Services and Outpatient Coding Guidelines" do not address correct diagnostic coding. However, as a result of the audit findings, more complete instructions will be written into the revised guidelines that will soon be finalized. Until further guidance is available, the following is excerpted from the publication by Faye Brown's ICD9-CM Coding Handbook and should be used.

"The V57.1 should not be used on all encounters for physical therapy although it is appropriate in most cases other than the initial evaluation, a true/complete re-evaluation, and post-surgical, or educational treatment. It is dependent on what services were rendered and documented. In cases where the therapist and/or technician are performing follow up care (manipulation, E-stimulation, traction, taping...with no post-surgical condition) the V57 code is used. Another example would be, if a patient is seen in physical therapy for range of motion exercises for his shoulder as the result of a fracture three months ago and now is experiencing stiffness of the joint, the V57.1 will be listed as the primary and the stiffness in joint (719.51) would be listed as an additional code.

The V57.1 code may be listed as either a principal or as an additional code. However, as stated in Faye Brown's book, "A code from category V57 **Care involving use of rehabilitation procedures**, is assigned as the principal diagnosis when the patient is seen for purposes of rehabilitation following previous illness or injury, with the fourth digit indicating the focus of treatment. An additional code is assigned for the residual condition requiring rehabilitation. No code for the original injury or illness that led to the disability is assigned."

This is somewhat confusing to us in a military setting as we are not necessarily in the traditional rehabilitation environment and are more focused on acute intervention for current conditions that are not 'residual' in nature. When we think of rehabilitation we envision inpatient/all day outpatient care for conditions such as strokes or amputations. Most of these type cases may be referred to a network provider in today's environment.

If the patient is coming in for counseling or educational classes, the V57.1 code is not necessary. If the patient is being seen by the therapist to outline his treatment regimen which is usually accomplished on the first visit, then you should code to the appropriate level of evaluation provided and the appropriate diagnosis code (symptom or residual condition) that brought the patient to physical therapy in the first place. When treatment begins, whether by a therapist or a technician, then use V57.1 as the primary diagnosis. The residual condition is an additional code to describe what is being treated—regardless of who provides the treatment, the therapist or the technician.

If during the initial examination and evaluation, provocative tests point to a more accurate diagnosis than that of the referring provider, Physical Therapists may use the more definitive diagnosis. Example: Provider X refers patient to Physical Therapy

with diagnosis of back pain…after complete evaluation (including documentation), the Physical Therapist determines the pain is due to sciatica (724.3), that is the diagnosis used.

Use of Evaluation & Management (E&M) codes will depend on the services provided during the encounter. If the patient is being seen for an initial physical therapy evaluation, the appropriate code is 97001; any re-evaluation for the same condition will be coded 97002. E&M code 99499 will be used when any treatment modality is administered.

The following are the top deficiencies in documentation and code assignment recently identified by internal coding auditors and 3M auditors.

- No documentation of time spent with patient receiving treatment modality
- No documentation of time technician spent working with patient on therapeutic exercises
- No inclusion of technician time with that of the Physical/Occupational Therapist
- Multiple units of service are not being coded
- Physical Therapy Technicians using initial evaluation and assessment E&M codes

Important to Document and Code Diabetic Manifestations

Category 250 is used to classify diabetes mellitus. The complete code has 4th and 5th digits.

The 4th digit identifies the presence of coma or systemic manifestations. Categories 250.4-250.8 represent a cause and effect relationship with the diabetes. They are presented as inseparable or "paired" codes in the Alphabetic Index. These paired codes are sequenced so that the underlying cause (diabetes) is always positioned first; it is followed by the manifestation code (nephrosis, neuropathy, etc). The physician should specify in the diagnosis that the condition is diabetic or due to diabetes, otherwise it is presumed not to be caused by the diabetes. There is one exception: diabetic gangrene or diabetes with gangrene will be coded as 250.7x [785.4].

The 5th digit sub-classification specifies the type of diabetes. Is it *non-insulin dependent* (NIDDM, adult-onset type) or *insulin dependent* (IDDM, juvenile type)? Is it controlled or uncontrolled? *Brittle* is considered "uncontrolled" for classification purposes at the 5th digit level.

Whether the DM is controlled or not, if the patient has systemic manifestations, assign the code that identifies the specific complication (i.e. renal, ophthalmic, neurological, peripheral circulatory and other manifestations). When the provider does not specify the type of diabetes, and whether the disease is controlled or not, ask for clarification.

There are occasions when a non-insulin dependent patient requires insulin for a period of time, post-surgery, for example. For classification purposes, that is assigned 5th digit "0" or "2." Patient is still assigned a code for NIDDM.

Problem with Gestational Diabetes Skews Health Employer Data and Information Sets (HEDIS) Scores

Did you know that miscoding pregnant women as diabetics (648.**0**x + 250xx + systemic manifestation) rather than as *gestational* diabetics (648.**8**x) could skew your HEDIS scores? Take for example a facility that has 100 diabetics. If 70 of those diabetics have had at least one retinal exam in the last two years, the retinopathy screening HEDIS score is 70%. And that's a great score compared to other health care systems. But, if you miscode just 10 women who had gestational diabetes as diabetics (648.**0**x instead of 648.**8**x), your denominator for the metric will be erroneously inflated by 10. Now your retinal exam metric is 70/110 or 64%. Guess what? Miscoding has just lowered your score by 6 points!

More on Coding our Diabetic Population

On a positive note, capturing co-morbidities such as diabetes helps define HEDIS measures and better describes the case acuity. On the down side, we have problems in diabetic coding, most evident in obstetrics and the older population.

Too often records of obstetrical patients are identified as diabetics on one admission (648.0x), *gestational* diabetics (648.8x) on the next, and back again to diabetics (648.0x). We also see the reverse situation. It's inconsistencies like these that skew the HEDIS statistics.

Records of older patients (>65 yrs) assigned diabetes code 250.00 (NIDDM or NOS w/o complications) come through the system. These same cases have additional diagnoses exhibiting circulation problems, retinal or nephritic conditions. The presence or absence of systemic manifestations plays a major role in assigning diabetic codes.

Remember, too, that *controlled* glucose levels does not equate to *without complications* (250.00 DM without complications). Controlled vs. uncontrolled status is identified by the 5th digit of the diabetes code. Complications or manifestations are the basis for code selection at the 4th level.

And the above is not unique to ambulatory patients. These coding trends are apparent in both inpatient and outpatient coding. Could it be that we need focused audits for the coding diabetes and its manifestations?

Standard Inpatient Data Record (SIDR) and Worldwide Workload Report (WWR): The Other Product Lines

With the impetus to improve timeliness and completeness metrics for the Standard Ambulatory Data Record (SADR) sites have forgotten that other product lines exist. The SIDR and WWR metrics should also be monitored.

Both the SIDR and WWR files should be transmitted by the 5th working day of every month. The inpatient record completion standard is 30 days from date of discharge.

Not with the same granularity, but BDQAS displays metrics for inpatient record completion and timeliness as well. These metrics compare SIDR to WWR on a monthly basis (12-month sliding window) as well as provide a fiscal year comparison. Percentages of SIDR coding completion and a Transmission Report to track the transmittal of inpatient record files are provided. The metrics would be useful to the person doing data queries who just knows there were more than 20 admissions for fractures in a given period and why only 5 are showing up in the database.

Besides the comparison of WWR to SIDR counts, there's also a 6-Month (WWR) Completeness Report that identifies late reports at a glance (dates are noted in red ink). Disparities in SIDR-WWR counts shown in the FY Comparison Report often indicate the need for further research or recalculation of the WWR report.

Do MTFs need to address inpatient and WWR metrics? **Most definitely**! Why not start here…. https://bdqas.afms.mil/csv/afvrpt03.html/ and https://bdqas.afms.mil/csv/afvpt02.html?

Activities of Daily Living (ADL) Training and Physical Therapy

To report self-care/home management training services like instruction of the patient on activities of daily living (ADL), see CPT code 97535. This code describes training on activities of daily living and compensatory training, meal preparation, safety procedures and instructions in use of assisted technological devices or adaptive equipment. The training is typically provided in patient's home or in a training environment designed to stimulate the patient's home environment.

ADL training **does not** mean use E & M codes 99341-99350. This range of codes is used to report "Home Services" or *services provided in a private residence*. Rarely, if at all, will these be coded in AF SADR.

Do a small focused audit to ensure these codes are being used properly. Here's another opportunity to excel!

Mental Health Super Bill Tailored for Convenience of Providers

The Mental Health Super Bill posted to the PHSD website https://phsd.afms.mil/ was created for the convenience of Mental and Behavioral Health providers as it translates ICD-9-CM termi-

nology of many of the diagnostic codes to DSM-IV language. An example of the disparity between the two codes systems is that it translates a diagnosis of Major Depression, moderate, DSM code 296, into ICD-9-CM, Affective Psychosis. The Mental Health Super Bill reflects the DSM terminology Major Depression, single episode, mild – ICD-9-CM code 296.21. Attached is the Mental Health Super Bill with DSM-IV conversions (atch 2). For those clinics using super bills, providers will find this tool to be very useful. Remember though, the terminology for codes in CHCS are still based on the ICD-9-CM translation.

Definitions for V70.5—X, Health Examination of Defined Populations (DoD Extender Codes)

PHSD continues to receive questions on the appropriate code assignments for the V70.5 code series with DoD extenders. Maybe these explanations will help the coder.

70.5 0 - Armed Forces Medical Exam - used for pre-enlistment exams. This is an initial qualifying examination to ensure individual meets the physical requirements to join the military. Usually these are done by a civilian provider. They may be done for dependents planning to join the military.

V70.5 1 - Aviation Exam - a subset of the occupational exam. This is the initial qualifying and recurring exam, usually done on an annual basis. The encounter usually occurs in the Flight Medicine Clinic.

V70.5 2 - Periodic Prevention Exam – This extender was initially established to identify encounters for Active Duty personnel undergoing the 5 year periodic prevention examination. As the standard of care changes, the frequency of encounters are decreasing. This is not to be confused with a preventive health assessment which is usually conducted by a technician and is no more than an administrative medical record review function. Also, this is not to be confused with a preventive health assessment (PHA) with examination done by a privileged provider (coded using the CPT E&M of 99420).

V70.5 3 - Occupational Exam - Used for both initial qualifying and recurring examinations due for individuals working in a specific occupation. For the occupational subset, aviation exams, use V70.5 1.

V70.5 4 - Pre-deployment Exam – This code identifies individuals undergoing an examination specifically because of deployment. At a minimum, the exam will be individualized based on the location, anticipated medical care in the area, and anticipated physical duties.

V70.5 5 - During Deployment Exam - Any examination while deployed that does not qualify for any of the other extenders. For instance, a fitness for duty exam during a deployment would be coded as a fitness for duty exam.

V70.5 6 - Post Deployment Exam - an examination specifically performed because an individual was deployed. This code will be used as a secondary code to identify deployment related issues (this will change as soon as there is a better method to collect this data). If patient is seen for conditions related to deployment, the V70.5 6 code is used as a secondary code.

V70.5 7 - Fitness for Duty Exam - used when the primary reason a patient is seen for profile changes, to be cleared for occupational activities, to be taken off "Duties Not Including Flying/Controlling", for "up chit", etc. For instance, a flyer was DNIF due to sinusitis. The flyer returns to be taken off DNIF, not that the standard of care for sinusitis requires a follow-up. This code may apply to Temporary Duty Retirement Lists (TDRLs), and Medical Evaluation Boards (MEBs), also.

V70.5 8 - Accession Exam - a baseline, usually for new recruits, officers and cadets.

V70.5 9 - Termination Exam - for retirement or

separation, for both optional and required exams.

SADR and SIDR Lessons Learned From the Field

Most personnel working in the coding arena seem to have adjusted well with ADM 3.0. There have been several issues relating to the recent patches and upgrades that were sent out, but most have been resolved.

The following explanation relates to some of these data transmission nuances and resolution to some of the fixes.

Problems solved:

1. We appear to have fixed the recent problem with data flow from Army and Navy CHCS hosts. The issue, whose typical manifestation was a huge number of attempted connections and resultant timeouts, was caused by a conflict with the establishment of a VPN to Brooks Epidemiological Laboratory in support of the Composite Healthcare Computer System (CHCS) Laboratory Interoperability Project. Teamwork between local base network staff, MHS, Defense Information System Agency (DISA), and the AFNOC helped find the solution.

2. Due to changes in the SADR extract file caused by implementation of DEERS/X12, we temporarily put a hold on any files with the new format. After careful testing and auditing, we are satisfied that the data is being loaded fully and correctly, and we are now accepting either record format (SADR version "B" or "C").

Opportunities upcoming:

1. There is an additional SADR record format change (SADR version "D") coming with the implementation of HIPAA Provider Taxonomy (Phase II) and HIPAA 837 Claims Processing. We have made preparations for this, but you may notice a slight delay in the processing of files, at least for the first sites that send the new format.

2. A more challenging task awaits us with the new format changes for the SIDR, as many fields changed position, and there is no format indicator in the file! We will keep you posted on our web site if there is any extended unavailability of the SIDR data.

If anyone has any questions or needs assistance with newly assigned system upgrades we would encourage you to contact the MHS Help Desk (1-800-600-9332) first. If you still cannot resolve your ADM concerns then by all means contact us at the Population Health Support Division.

Frequently Asked Questions

Q. In addition to using the CPT code for surgical endoscopy, is it appropriate to report 90784, *intravenous injection* and/or 90782, *therapeutic, prophylactic or diagnostic injection {specify material injected}; subcutaneous or intramuscular*?

A. No. Billing the endoscopy code alone is adequate for reimbursement under APVs, because a standard group of component codes is bundled into many of the endoscopy codes. For example, if your facility reports 44363, *small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of foreign body,* billing for injections (90782-90784) will not be separately reimbursed as they are already components of 44363.

Q. What are the correct codes to report chronic serous otitis media with placement of bilateral myringotomies with ventilating tubes?

A. The correct ICD9-CM code is 381.10, *chronic serous otitis media, simple or unspecified.* The correct CPT code, if procedure was performed under general anesthesia is 69436, *Tympanostomy (requiring insertion of ventilating tube), general anesthesia.* If the procedure was performed bilaterally, modifier – 50 must be applied to this code to correctly identify the surgery was performed as a bilateral procedure. In addition, a new code 69990, *surgical operating microscope,* may be appropriate, if a microscope was used to obtain good visualization of fine structures within the operating field.

Q. When is it appropriate to use V72.0, *examination of eyes and vision,* as a primary diagnosis?

A. The primary diagnosis for any outpatient encounter is "the reason for the encounter." If a patient comes to the Optometry Clinic for an annual examination, the V72.0, *examination of eyes and vision,* is the appropriate code. If the patient reported a problem, e.g., headache, myopia, astigmatism, blurred vision, etc., then the chief complaint or symptom would become the primary diagnosis. If problems were identified during encounter for the examination, the V72.0 is the primary code and any additional findings are coded as secondary diagnoses.

Q. Is it acceptable for the coder to code the diagnosis of tobacco abuse or use (ICD-9-CM 305.10), if the provider only documents this information in the patient's history?

A. The provider must document tobacco abuse or use disorder in his assessment/diagnoses before assigning the 305.10 ICD-9-CM code. Coding trainers should include this as a part of their training curricula….let them know there are several ways to code and track tobacco use, such as:

ICD-9CM Code	ICD-9-CM Description	Use
305.10	Tobacco Use Disorder	Current users of tobacco including smokeless tobacco products
V15.82	History of Tobacco	Previous users of tobacco products who currently do not use tobacco products. Generally, this is a secondary code when presenting symptoms are likely to be related

Frequently Asked Questions (Cont)

ICD-9CM Code	ICD-9-CM Description	Use
		to previous tobacco use
V65.49 4	Tobacco Cessation Counseling	Used when advice/counseling is provided to the patient on risks associate with tobacco use and the availability of treatment options.

Q. When is it appropriate to use ICD-9-CM V-codes for special screening examination encounters?

A. A special screening examination code is assigned to the encounter when the test is being performed in order to identify any disease or condition, e.g., carcinoma of colon or prostate carcinoma. Screenings are done on apparently well individuals who present with no sign or symptoms relative to the disease. If a screening examination identifies pathology, the code for the condition is assigned rather than a V code.

Q. Although most sites do not bill Medicare, is it appropriate to use the HCPCS screening codes, e.g., G0101, *Cervical or vaginal cancer screening; pelvic and clinical breast examination*?

A. Yes, whether an encounter is billable or not, the G1010 HCPCS screening codes are needed for continuity of population health.

To reach our coding consultants, contact

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